AN INTERPRETIVE DESCRIPTIVE QUALITATIVE STUDY OF MALE ICU NURSES’ EXPERIENCES IN TAKING CARE OF DYING PATIENTS

by

TAMMY W. WU

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ABSTRACT

Male nurses can bring energy and knowledge along with diverse beliefs and values to their workplaces. When taking care of dying patients, male ICU nurses may also have an array of issues concerning comfort care, and their unique ways of coping with stress that can accompany such events. Male ICU nurses also have distinct ways for maintaining their well-being and for sustaining their masculine ideals when caring for dying patients and working in a female-dominated environment. Many research studies have focused on how nurses care for dying patients, but few studies have explored the experiences of male ICU nurses caring for dying patients. The current study addresses this significant knowledge gap and provides valuable insights on how male ICU nurses connect masculine ideals with stress coping strategies in a female-dominated environment. Using an interpretive descriptive qualitative approach, this study provides understandings of male ICU nurses’ struggles and feelings when they witness their patients’ death.

The findings indicated that most participants drew on masculine ideals to act as providers in meeting the needs of the patients and their families. That said, most participants also transgressed some masculine ideals by expressing their feelings, such as shedding tears at the bedside and talking about their emotions to help reduce stress. Many participants also reported appreciating their life and their families more after witnessing patients’ death. They also used effective strategies to cope with the stress in their lives and workplace. Furthermore, participants believed that they were equals to the female nurses both in terms of competency and in their ability to care for patients and families. Finally, this study also enhances opportunity to learn how to increase understanding in supporting male ICU nurses at their workplaces.
PREFACE

This thesis is submitted in partial fulfillment of the requirements for the degree of Master of Science in Nursing. It contains work done from January 2012 to March 2013. My supervisor (Dr. John Oliffe) and my committee members (Dr. Joy Johnson and Dr. Vicky Bungay) are co-authors of the publication. I conducted the research and wrote the thesis with guidance and advice from my supervisor and committee members. Ethics approval for this project was granted by the University of British Columbia (UBC) Behavioural Research Ethics Board (H11-03077) in February 2012 by Akram Alfantazi and Nadia Rad.

Chapter 3 of this thesis is based on work conducted in two hospitals in Vancouver, BC, where I carried out the promotion, interviews, data collection and analysis, and wrote the thesis and documentation. The final themes and subthemes were reviewed and approved by Dr. John Oliffe, following the analysis process.

The findings presented in Chapters 4 to 6 have been analyzed and the conclusions are based on the interviews and information provided by the study participants. I designed the analysis process and obtained the final results, with revisions made according to the suggestions of my supervisor and committee members.

No parts of this study have been previously published. I conducted all interviews and wrote the thesis manuscript, having received much constructive feedback and support from my supervisor and committee members throughout the process.
# TABLE OF CONTENTS

Abstract ................................................................................................................................. ii
Preface ................................................................................................................................. iii
Table of Contents ................................................................................................................ iv
List of Tables ......................................................................................................................... vi
Acknowledgements ............................................................................................................. vii

Chapter 1: Introduction .................................................................................................... 1
  Problem Statement and Purpose ..................................................................................... 1
  Research Questions ......................................................................................................... 4
  Summary ........................................................................................................................... 4

Chapter 2: Literature Review ............................................................................................ 6
  Background ....................................................................................................................... 6
  Ethical Concerns ............................................................................................................. 6
  Stress and Coping ......................................................................................................... 7
  Masculinities .................................................................................................................. 8
  Summary ........................................................................................................................... 10

Chapter 3: Methods .......................................................................................................... 12
  Study Design ................................................................................................................... 13
    Sample .......................................................................................................................... 13
  Data Collection .............................................................................................................. 15
  Data Analysis ................................................................................................................ 16
  Ethical Considerations ................................................................................................. 17

Chapter 4: Findings .......................................................................................................... 18
  Ensuring a Dignified Death ............................................................................................ 18
  Changing the Focus From Patient to Family ................................................................. 23
  Being Emotionally Attached ........................................................................................ 28
    Trigger Points ............................................................................................................... 29
    Shedding Tears ............................................................................................................ 31
    Staying Positive .......................................................................................................... 32
  Stress and Coping ......................................................................................................... 35
    Sources of Stress ......................................................................................................... 35
    Coping Strategies ....................................................................................................... 37
LIST OF TABLES

Table 3.1: Participant Characteristics ........................................................................................................ 14
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I am especially grateful to my supervisor, Dr. John Oliffe, for his patience and guidance throughout the two years of my studies, and for offering me encouragement in facing each new challenge. I am also grateful for the advice and support from my thesis committee members, Dr. Joy Johnson and Dr. Vicky Bungay. I appreciate the time and constructive feedback they offered to help fine-tune my project.

Finally, I would like to acknowledge the financial support from the Katherine McMillan Director’s Discretionary Fund of the University of British Columbia, School of Nursing, for the research bursary that supported my thesis studies.
CHAPTER 1: INTRODUCTION

Background

Traditionally, men have been identified as being strong and influential in many situations, including their workplaces. Sometimes, men are also labelled as being “clumsy” and “incapable of caring adequately for persons experiencing sickness or an injury” (Burns, 1998, p. 695). These male stereotypes, as mutually exclusive binaries, do not adequately account for the diversity of characteristics among male nurses, for example, men can be caring and considerate in their work and at their workplaces. Like many female nurses, male intensive care (ICU) nurses are often assigned to care for dying patients and their families. Although male ICU nurses respond to stress and frustration in various ways, few studies have explored the experiences of male nurses, especially male ICU nurses’ experiences of caring for dying patients and their families. This qualitative, interpretive descriptive study, explored male ICU nurses’ experiences of caring for dying patients. The background to the problem, research questions, and theoretical framework are introduced and briefly described in the following sections.

Problem Statement and Purpose

This study explored the experiences of male ICU nurses in their care of dying patients and their families. In the ICU, critically ill patients are typically on a technologically advanced organ support system, receive aggressive care, and are monitored continuously (Espinosa, Young, Symes, Haile, & Walsh, 2010). Some ICU patients will survive and be restored to a normal functional existence; however, many will die and this emotionally affects their families and the staff who care for them (Wilson & Pace, 2004). Moreover, futile resuscitation of dying patients in the ICU can impose a financial drain on the limited resources of the healthcare system; the provision of quality
end-of-life care is thus a priority for the healthcare team (Wilson & Pace, 2004). Some studies have found that a majority of the ICU deaths involve withholding or withdrawing life-sustaining treatments, factors that contribute to nurses’ stress (Curtis & Vincent, 2010; Espinosa et al., 2010). Curtis and Vincent (2010) maintain that the purpose of withholding or withdrawing life support treatment is “to restrict life-sustaining treatments” (p. 1350). Wilson and Pace (2004) argue that the difference between withdrawing or withholding treatment and allowing a natural death “appears to be a clear distinction between allowing a patient to die and killing them, i.e., there is a distinction between actively doing something and letting something happen” (p. 416), which makes the intention of the action most important. From a multidisciplinary team point of view, withholding or withdrawing treatment is an “interactional strategy, in which the timing of treatment withdrawal is carefully planned, and is accompanied by expressions of belief about the causation of death and the distribution of responsibility for decision-making between clinicians, patients, nurses, and family members” (Seymour, 2000, p. 1244). The underlying principle that guides any decision on continuation, escalation, withholding, or withdrawing treatment must be to protect the dignity, rights, and comfort of the patients as well as considering the wishes of the patient or whoever holds their power of attorney (Wilson & Pace, 2004). A patient’s death has been described as when “cardiopulmonary arrest represents a terminal event in their illness and … the delivery of CPR would be inappropriate” (Wilson & Pace, 2004, p. 415). Wilson and Pace (2004), also describe brain death, defined as the loss of whole brain function, including the brainstem, as a type of death.

Taking care of a dying patient can be an emotionally draining experience (Wilson & Pace, 2004). While many reviews (e.g., Curtis & Vincent, 2010; McMillen, 2008; Seymour, 2000) have explored the experiences of nurses who provide palliative care to
their patients, few studies have specifically addressed the experiences of male ICU nurses in caring for dying patients and their families. Thus, to address this knowledge gap, this study focused on male nurses who worked in ICUs.

Male nurses are generally seen as being in control and authoritative in their workplaces (McMurry, 2011), but little is known about their experiences of caring for dying patients. Limited research exists that explores male ICU nurses’ experiences and how they maintain their well-being by connecting their masculine ideals with various coping strategies. Little is known about how they feel about life and death during the course of providing comfort care to their patients. Moreover, no study has reported on how witnessing the death of their patients influences the way male nurses appreciate life and work, cope with stress, or view satisfaction at their workplaces. Few masculinity studies that have focused on male nurses have considered their stress and coping mechanisms or how they maintain their well-being under stressful and emotional situations (e.g., Evans, 2004; McMurry, 2011).

Mandy, Cummings, Newburn-Cook, and Lo (2009) reported that, on average, healthcare professionals are 1.5 times more likely to be absent from work as a result of illness or injury than professionals from other occupations. In a review article by the Department of Health (United Kingdom) (2010) it was reported that more than 25% of nursing staff absenteeism was due to stress, depression, or anxiety, and many staff members abandoned the profession because of disappointment and infirmity. Male nurses with absenteeism reported high job strain; high physical demands on the job; and high overload, burnout, and stress as factors for their absenteeism (Mandy et al., 2009). According to Poncet et al. (2007), one third of nursing staff working in ICU experiences severe workplace burnout. Burnout has been defined as “a collection of symptoms linked
to emotional exhaustion” (Young, Derr, Cicchillo, & Bressler, 2011, p. 228). According to Young et al. (2011), burnout happens gradually and results in increased work relationship problems, decreased productivity, negative emotions, compulsive behaviors, and trouble relating to family, friends, and coworkers. Factors that contribute to burnout include increased nurse workloads, managing time constraints, complex patient assignments, and lack of control and reward. Burnout among nurses can also result from emotional exhaustion, depersonalization, decreased enthusiasm for the job, and decreased job performance (Young et al., 2011). All these factors can directly affect the quality of patient care, patient safety, and outcomes. Exploring the connections between masculinity and stress and coping in the context of caring for dying patients in the ICU can provide valuable insights on the distinct ways male ICU nurses maintain their well-being and sustain their masculine ideals when providing care in a typically female-dominated work role. By promoting men’s health and well-being, direct benefits for patient care and job sustainability can also be garnered.

**Research Questions**

The specific research questions that guided this study were:

- What are the connections between masculinities and stress and coping among male nurses when caring for dying patients and their families?
- What strategies best support and sustain male ICU nurses who are caring for dying patients and their families?

**Summary**

Each day, many ICU deaths involve withholding or withdrawing life-sustaining treatment. Taking care of a dying patient and supporting their families can be an emotionally draining experience for both male and female ICU nurses. Men are often stereotyped as strong and influential in many situations but clumsy and incapable of
caring adequately for persons experiencing sickness. While male ICU nurses are seen as being in control and authoritative in their workplaces, little is known about their experiences of caring for dying patients. To address this knowledge gap, this study explored how male ICU nurses sustain their masculine ideals and cope with stress when caring for the dying patients. The following chapter examines the theory of masculinity and stress and coping that guided this study.
CHAPTER 2: LITERATURE REVIEW

Background

Critically ill patients are closely cared for in the ICU. As Espinosa et al. (2010) suggest, “the primary goal of aggressive care in the ICU is to stabilize and restore patients to their prior state of health” (p. 273). Patients who are admitted to the ICU may experience a complex mix of acute and chronic pathologies and “between 15–35% die during intensive therapy” (Seymour, 2000, p. 1242). Recent studies indicate that a majority of the ICU deaths involve withholding or withdrawing of life-sustaining treatments (Espinosa et al., 2010). With the high death rate associated with patients in ICU, nurses often care for dying patients and their families, which can be challenging. McMillen (2008) asserts that adjusting the focus from providing active resuscitation to withdrawal of active treatment is demanding for nurses as they have to reset their goal from aggressively treating patients to keeping them comfortable and ensuring a good death. In addition, nurses can become emotionally involved as they provide care to dying patients and support to the family during these difficult times (McMillen, 2008). Consequently, ICU nurses who deliver terminal care can experience stress, moral distress, death anxiety, suffering, and burnout (Espinosa et al., 2010).

Ethical Concerns

When caring for dying patients nurse can often encounter ethical concerns. Such concerns are expressed over the gray areas residing within and between euthanasia and withdrawal of treatment (Seymour, 2000). A morally important distinction has been made between directly and indirectly causing death and the intention of decision-makers who support the terminal treatment of dying patients (Bishop, 2006). Clinical procedures, such as turning off inotropics or withdrawing ventilator support, are usually planned
(Curtis & Vincent, 2010). Some nurses, however, fear that actions accelerating death are actions approaching euthanasia (McMillen, 2008). Besides personal struggles, nurses can experience moral distress when disagreements arise among care providers or between care providers and family members over decisions to withdraw or withhold treatment (McMillen, 2008). McMillen (2008) identified stressful factors and situations where delays occurred in decision-making that resulted in unnecessary suffering for the patient and family. Nurses can become emotionally involved when caring for dying patients and when withdrawing treatment, especially from young patients (McMillen, 2008). In many cases, however, difficulties arise over predicting whether withdrawing treatment is prolonging inevitable death or facilitating the chance for a recovery (Seymour, 2000).

**Stress and Coping**

According to McMillen (2008), nurses may experience anger, frustration, and powerlessness when caring for dying patients. They often face difficulties in providing a supportive environment that will optimize control, and ensure emotional comfort and patient dignity. Some nurses report that when they “witnessed the patients’ and the family members’ pain and suffering at the end of life, [they], too, felt pain” (Calvin, Kite-Powell, & Hickey, 2007, p. 148). Conversely, Calvin et al. (2007) asserted that, despite the challenges and difficulties in caring for patients at the end of life, some nurses reported that their endeavors were worthwhile and they felt privileged and honored to take care of patients during this challenging time.

Since taking care of dying patients can be challenging, nurses need to use effective coping strategies. In the current study, the theory of stress and coping (Lazarus & Folkman, 1984) features as one of the conceptual frameworks. The model can be used to explain how individuals muster their resources and coping strategies to deal with
internal or external stresses (Polit & Beck, 2008). Larzarus and Folkman (1984) explained that dealing with stress is about one’s control in stressful transactions, the relationships between control and coping, and the adaptation outcomes of stressful encounters.

Diverse coping strategies can also affect nurses’ experiences, some of which can lead to positive emotions when facing challenges. By transforming a difficult situation, nurses can be empowered to normalize a challenging event and use it to find meaning in their lives. For example, some nurses have their family and friends as support systems and/or debrief with colleagues at work. Espinosa et al. (2010) suggest that some nurses verbally share their experiences with others, avoid taking care of dying patients, and/or use humour to deal with a sad situation. Many female nurses have reported that they sometimes cry, indicating that this “did not interfere with the care they were delivering, but that crying with the family and other staff helped them cope with the loss of the patient” (Espinosa et al., 2010, p. 278).

**Masculinities**

According to the Government of Canada (2012), men represented 5.3% of nurses employed in 2003. In some sources men have been portrayed as “clumsy” and “incapable of caring adequately for persons experiencing sickness or an injury” (Burns, 1998, p. 695). Nevertheless, more recent accounts acknowledge that male nurses may have similar qualities and motivations as their female counterparts in that they like people, want to help others, and believe nursing will be an interesting and secure profession (Dyck, Oliffe, Phinney, & Garrett, 2009).

Connell’s (1995) masculinities framework has been adapted by researchers to describe a plurality of gender performances that are taken up by male nurses. According to Oliffe et al. (in press) social constructionist gender work can be identified as two
principles: (1) patriarchal power and characteristics, including self-sufficiency and competitiveness, which are known as hegemonic masculine ideals that influence men’s practices and experiences; and (2) a plurality of context-dependent masculine performances that are embodied by men in relation to dominant ideals of masculinity. According to Connell (2005), there are multiple masculinities, such as hegemony, subordination, complicity, and marginalization. Hegemonic masculinity is established when there is some correspondence between the cultural ideal and institutional power; for example, the top level of business, the military and government, which are the successful claim to authority, can be challenged by any group of men or even women when their defense of patriarchy change (Connell, 2005). Subordination masculinity is related to cultural dominance in society and cultural stigmatization against gay men—including political and cultural exclusion, legal violence, economic discrimination—reflecting that homosexual masculinities are considered as at the bottom of a gender hierarchy among men (Connell, 2005). Complicity masculinity is the normative notion of masculinity, and the majority of men who align with this type of masculinity gain benefit from the patriarchal dividend, especially from the overall subordination of women (Connell, 2005). Marginalization is related to a social dynamic in which class and race relations are simultaneously in play, such as the institutional oppression against the Black communities (Connell, 2005).

Men tend to have their own unique approach to coping with stress to maintain health. Men often handle stress by spending time with their friends and families; for instance, having a beer with friends, going for a walk with a spouse, or going fishing or bird watching with the children (Hollnagel, Malterud, & Witt, 2000). Many men outwardly exhibit positive, carefree, and cheerful attitudes about life, thus allowing them to optimize their ability to enjoy life (Hollnagel et al., 2000). Some men suggest that job
satisfaction enables them to “feel strong,” and that work pressure can drive them to perform in their jobs, even when they are not well (Hollnagel et al., 2000). Moreover, being idle, passive, and bored makes men feel weary and dull (Hollnagel et al., 2000). Emslie, Hunt, and O’Brien (2004) asked whether men “live to work” or “work to live,” and suggested that most men live to work. Similarly, according to Oliffe et al. (in press), a close relationship exists between the loss of a job, which may be due to retirement or other reasons, and depression. Men’s worth is often indirectly measured by their performance, ability, and accomplishment at their workplaces (Oliffe et al., in press).

Traditionally, male nurses are perceived as physically powerful, which situates them in positions requiring strength to protect others (Evans, 2004). They are expected to fight in defense of their patients and female colleagues, which subsequently promotes the image of male nurses as neither gentle nor caring (Evans, 2004). This image affirms the masculine identity of male nurses and distances them from the feminine image of nursing (Evans, 2004). Matthews (2001) found that when asked to describe the care they provide, male nurses tend to focus on technical aspects, including taking blood pressure and dispensing medications. Similarly, Evans (2004) pointed out that male nurses tend to gravitate towards managerial positions (positions of power), and areas of high technology as a way of maintaining their masculinity. Within contemporary practice, many male nurses prefer to work in ICUs, since particular clinical and administrative work can appeal to men because of the challenges and the respect garnered from others who work in these high adrenaline areas (Schoonover-Shoffner, 2006).

**Summary**

About one third of critically ill patients die from the withdrawal or withholding of life-sustaining treatment in the ICU. Many nurses experience moral distress and express
ethical concerns when terminating care for dying patients. Studies show that nurses cope with stress in diverse ways after they witness their patients die in the ICU. For male nurses, studies have portrayed them as physically powerful, focused on technical aspects, and preferring to work in high adrenaline areas to maintain their masculinity. In this thesis I explore the relationship between coping strategies and masculinities and how male ICU nurses maintain their well-being when caring for dying patients.
CHAPTER 3: METHODS

The current research study is guided by the interpretive descriptive methods. The approach was used to gain knowledge that “straddles the chasm between objective neutrality and abject theorizing, to extend a form of understanding that is of practical importance to the applied disciplines within the context of their distinctive social mandates” (Thorne, 2008, p. 26). As an applied qualitative research approach, interpretive description can afford understandings of complex experiential clinical phenomena within nursing, in regards to applied health knowledge from areas that we want to know more about (Thorne, 2008). It also provides a logical model for generating meaningful scholarly products with application utility in nursing and other health fields (Thorne, 2008).

Interpretive description allows researchers to enter the field in a logical, systematic and defensible manner, and offers the potential to explore new knowledge from different perspectives for the application of new insights and evidence into practice (Thorne, 2008). This serves to ensure the integrity of the project for the applied disciplinary world (Thorne, 2008). Moreover, interpretive description reflects a kind of mental attitude that helps one discover associations, relationships, and patterns within the phenomenon, and through integrating what we learn with our reflective clinical reasoning processes. By searching for underlying meanings, the approach allows researchers to move a step closer to general knowledge (Thorne, 2008). Consequently, interpretive descriptive methods enable researchers to explore a clinical phenomenon to gain more knowledge, in this case, to reflect on the experience of male ICU nurses.
**Study Design**

**Sample**

The data collection process began in the intensive care units (ICU) at two Vancouver-based acute care hospitals in April, 2012. Data collection occurred over three months (April–July, 2012). Eligibility criteria for participation in this study were male ICU nurses who: were biologically born male or self-identified as male; spoke and understood English; were of various ethnicities (e.g., Anglo-Canadian, Asian), and sexualities (e.g., gay, bisexual, or straight); currently working (full-time or part-time) in the ICU and had cared for dying patients in the ICU.

Posters used for advertising the study were placed on different notice boards in the ICUs in the two hospitals. Over the next few weeks, three prospective participants approached me voluntarily, and I also approached other potential participants. Reminders for the interviews were sent to the participants by email, text messages, and verbally in-person. The locations of the interviews were chosen by the participants, and interviews were held at various locations, including the hospital family meeting rooms, patient bedsides, restaurants, cafeterias, and at the homes of participants.

At the beginning of each interview, the purpose of the study, process for protecting confidentiality of the participant, data collection methods, and audio-recording methods were explained. Demographic data forms (Appendix A) were completed and consent forms (Appendix B) were signed prior to the interviews. After each interview, field notes, methodological memos, and reflective memos were written within 24 hours to facilitate an accurate recall of what was observed and understood during the interview.

A total of 10 male nurses from one hospital and five male nurses from another hospital participated in the study; most of the interviews were held during the
participants’ day off or in the few hours before they began their shifts, as requested.

Participants had worked in the ICU from two months to 16 years ($M = 8$ years). The demographics of participants are shown in Table 3.1 below. Some participants expressed concerns about providing unsound or irrelevant information during the interviews; however, they were all reassured about the value of their contributions.

**Table 3.1: Participant Characteristics**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Age range = 28–48 ($M = 38$)</td>
<td></td>
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</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time</td>
<td>14</td>
<td>(93%)</td>
</tr>
<tr>
<td>Full-time</td>
<td>1</td>
<td>(7% )</td>
</tr>
<tr>
<td>Training received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>11</td>
<td>(72%)</td>
</tr>
<tr>
<td>Sweden</td>
<td>1</td>
<td>(7% )</td>
</tr>
<tr>
<td>Philippines</td>
<td>1</td>
<td>(7% )</td>
</tr>
<tr>
<td>England</td>
<td>1</td>
<td>(7% )</td>
</tr>
<tr>
<td>Not stated</td>
<td>1</td>
<td>(7% )</td>
</tr>
<tr>
<td>Qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s degree</td>
<td>1</td>
<td>(7% )</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>11</td>
<td>(72%)</td>
</tr>
<tr>
<td>Nursing diploma</td>
<td>3</td>
<td>(21%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anglo-Canadians</td>
<td>10</td>
<td>(67%)</td>
</tr>
<tr>
<td>Filipino</td>
<td>2</td>
<td>(13%)</td>
</tr>
<tr>
<td>Chinese</td>
<td>2</td>
<td>(13%)</td>
</tr>
</tbody>
</table>
Most participants had never participated in a qualitative study, though they were all very open to sharing their experiences. One participant stated that he had limited experience in taking care of dying patients in the ICU, though he was willing to participate in the study. Most participants said that they had taken care of dying patients, not just in the ICU, but in other areas of practice.

**Data Collection**

Most of the interviews were held in the ICU before or after each participant’s scheduled shift. Some of the participants seemed to be tired after working their 12-hour shift, and some appeared to be rushing to get through the interview, before they began their shift. The interview conditions may have affected the quality of the data for some of the participants, who may not have been able to relax fully and discuss the questions. As a suggestion for future research of this kind, the time and dates of interviews need to be well planned to facilitate the collection of rich data. At the beginning of the interviews, most participants appeared to be slightly anxious. Rapport was established by reassuring them that the interview would be simple and straightforward. During the interviews, participants were polite and friendly. Most participants sat adjacent to or across from me and their body posture suggested that they were relaxed and open. They seemed to be comfortable during the interviews, which was indicated by their posture (i.e., leaning
back against their chair and making light conversation), especially as the discussion progressed.

The interviews were conducted in places where we would both feel safe and comfortable, with the aim of promoting an engaging environment for the interviews. During the interviews, one digital audio-recorder and a back-up audio-recorder were used to record the conversations. Almost all participants were interested in finding out why I had chosen to focus on male ICU nurses, instead of female ICU nurses, for my research topic. After I answered the question, many of them said that they wanted to be understood by others and they were happy to share their experiences. The participants all indicated that they enjoyed the interviews.

After each interview, I made field notes and memos within 24 hours, with careful recording of the details of participants, such as how they dressed, their posture, and the environment. As an ICU nurse, my own perspectives, experiences, and recollections about the care of dying patients may have also influenced the interpretation and analysis of the data; thus, to minimize possible data contamination and biases, I was reflexive throughout the data collection. This included writing ongoing journals and memos to reflect on my own biases, actions, feelings, and conflicts. I also discussed my concerns with my supervisor during data collection and analysis, a process known as peer review (Holloway & Wheeler, 2010), to reduce any biases and to increase the trustworthiness of the study findings.

**Data Analysis**

After the interviews, the data were transcribed verbatim by a professional transcriptionist, and subsequently checked against the audio-recordings to ensure its accuracy. I then reviewed and began interpreting the data line-by-line, examining
similarities and differences while developing tentative codes for organizing the segments of data. After reviewing the coded data several times, inductively derived themes and sub-themes began to emerge. Next, I used analytic memos to jot down key elements, inquiries, reflections, and analysis to help develop further interpretations and descriptions of the data. Then, I reviewed the raw data again, color-coding illustrative quotes, and categorizing them under each theme and sub-theme. I carefully interpreted and described the data and reassessed the findings several times to ensure accuracy throughout the process. In writing up the findings, I reviewed published studies and responded to comments and questions from my supervisor. This was done to advance the analysis while ensuring the representativeness of the data and the interpretations, in particular, the underlying meaning or embedded masculine ideals that corresponded to the participants’ answers. The main themes of the study included: ensuring a dignified death, changing the focus from patient to family, being emotionally attached, stress and coping, and supporting male ICU nurses in a role that is female-dominated.

**Ethical Considerations**

Ethics aim to protect the dignity, rights, safety, and well-being of participants (Holloway & Wheeler, 2010). Prior to initiating study recruitment and data collection, ethical approval was obtained from the UBC Behavioral Research Ethics Board (BREB), the Vancouver Coastal Health Research Institute, and the Providence Health Care Research Institute. During the recruitment process, information about the purpose of the research study was clearly stated in flyers and emails. Before the participants signed their consent forms, the purpose of the study, details about how the data would be stored, and who would be able to read the data and the interpretations (i.e., the supervisor and the committee members) were provided to the participants. Any questions from the participants about the study were answered. Since the participants were asked to describe
their memories/stories/experiences about taking care of dying patients in the ICU, a potential for psychological harm (e.g., sadness, negative emotions/discomfort) existed during and after the interviews. The potential harms were written in the consent form and the participants were advised of them verbally before they were asked to give their consent. To manage the possible harm, written information about the availability of workplace counseling services was given to each participant prior to their interview. Participants were also told that they had the right to withdraw from the study at any time during the process. A safe environment was provided for the interviews, and all candidates participated voluntarily. Furthermore, to promote confidentiality, pseudonyms were used during the data analysis process and are included in the findings.
CHAPTER 4: FINDINGS

In the hospitals where the participants worked formal ‘comfort care’ practice guidelines were in place to direct the work of nurses caring for dying patients. Included were pre-printed orders guiding the withdrawal of any unnecessary treatments that may inadvertently inflict pain on a patient, along with comfort measures—including the specificities of sedative and analgesia infusions to promote rest and relief for patients who are dying. Many participants suggested that their comfort care goal was to ensure patients would be free of pain and anxiety. They also believed that dying patients should have control over how and with whom they spent their time. Within this process, most participants reported displaying a mix of strength (patient advocacy) and emotion (visible expressions of sadness) responses that might reasonably be argued to align, but also run counter, to some masculine ideals. During the dying process, participants are required to successfully cope with stress by connecting and sustaining their masculine ideas with their coping strategies in order to maintain their well-being. The main themes of this study included how male ICU nurses provide a dignified death for their patients, how they change their focus from caring for the patients to their families, their feeling about being emotionally attached after seeing their patients die, their ability and strategies to cope with stress, and how they feel about working in a female-dominated profession.

Ensuring a Dignified Death

When asked about providing comfort care for dying patients, most participants stated that providing a dignified death, such as respecting a patient’s wishes and caring for their immediate needs, were crucial. Some participants also highlighted that “no pain and no fear” was the primary goal for patient care. Philip suggested:
There’s only two things that I need to worry about if I go to a dying patient; one of them is that he’s not in pain, and the other one is that they’re not scared. . . . That’s my job.

Evident in Philip’s and many other participants’ interviews were compassion amid a rational approach to relieving pain and anxiety among their patients, especially for those who were dying. Adam articulated a similar point of view, but his focus was on promoting a peaceful death through providing basic comfort care along with analgesia:

Comfort care means that we make the patient as comfortable as possible by, you know, stopping things that are not necessary, that will only make him suffer more, giving him enough sedation and analgesia for the patient to, you know, to die peacefully and quietly, and not to feel any pain, and not to struggle with it.

Comfort care extended beyond following a pre-printed, standing analgesia and sedation order reviewed and signed by the doctor, to include measures to meet the patients’ needs to make their dying process easier. It required participants to be empathetic throughout the process. Comfort care was also understood by participants as including fewer institutional routines and regulations and, where possible, letting patients decide what was best for them, both physically and emotionally. Luke asserted that it was a personal time during which patients and their families decided how they wanted to spend their final moments together:

In the occasion when you look after a patient who’s interactive, then you kind of want to ask him, ‘Well, what do you want to do? Well, this is all about you, this is your time’. Um, you know, he would make the decision of how comfortable he wants to be. [Some patients] . . . have zero tolerance of any discomfort, just you know, go and focus on the physical component of it, but other patients might just want to hang out with the family longer, and then maybe, some degree of physical discomfort is tolerable. . . . So it’s really what the patient wants and then if the patient is not interactive at all then it will be, basically the physical component of comfort.
Comfort care focused on how patients wanted to spend their final moments in meaningful ways. Often, patients had to choose between physical suffering and quality time with their family. As for the participants, their goal was to respect and support their patients’ decisions in their final moments. Some participants believed that when medical treatments were futile, patients had the right to request comfort care. Mark explained:

To my mind, I always respect everybody’s dignity, you know, I myself don’t want to be, like, yeah, if there’s no hope, I don’t want to be resuscitated or anything like that, so that’s my principle, you know, I always respect others’ wishes as well, if somebody wishes not to be resuscitated then so be it.

It was recognized that patients had the right to choose what they wanted when medical science could not sustain their lives. In describing this right, many participants reflected on what could happen to them in similar circumstances and the options that they had to keep things under their control.

Mike also expressed his view about the comfort care protocol at the institution where he worked. While he recognized the work that went into the guidelines and orders, he also suggested that a personal approach was required:

Obviously they took a lot of time to develop those kinds of protocols . . . I’m sure there’s a lot of work that went into them. Even though it’s a fairly simple order sheet, I’m sure they have to go through the whole process of, you know, the administrative and all that stuff. They have to do all those pre-printed orders. So, I’m sure that there is due process. So, from that sense, I’m comfortable with it. But from a personal sense, I think it’s, um, making them [patients] comfortable and just being as humane as possible . . . you know, nothing’s gonna stop them from dying, so it’s just best to make them as comfortable as possible, right?

Some participants suggested a logical and in-control approach when caring for dying patients. They evaluated whether or not the guidelines and protocols were reasonable and best for their patients before bringing them to the bedside. This indicated
that they wanted to protect and provide the best care for their patients. When asked about
their feeling of having sedative and analgesia infusions as part of the comfort care
protocol, most participants believed that the medications would expedite the dying
process; yet their own comfort levels were diverse about administering those drugs. Many
participants agreed that comfort care was humane and preserved the patient’s dignity.
Jacob explained:

It’s for comfort and it’s also to expedite the process. It’s also, um, it’s the reality of life, you
know, death is not, we are very far removed from the natural way of death. I mean, a
hundred years ago, death was not this sanitized process. It takes people days to die, weeks
sometimes, and people died slow, agonizing deaths in their bed, in their house or wherever
they were . . . We don’t allow that to happen here because we don’t have to. So, the drugs
are comfort. You know, between us and as any nurse knows, and doctors know, they
expedite the process. It takes something that would take two weeks and gets it done in 12
hours. That’s really what it does. Um, and I guess it’s ultimately, and I mean, I don’t have
an issue in that at all because I would want that done for myself or for anyone I loved. You
know, it’s the most humane thing.

More than just providing comfort care, the healthcare team was described as
having control over the entire dying process, such as its length and the medications that
were administered. The descriptions were very clinical and task-oriented. A few
participants suggested that giving sedatives and narcotics was to promote comfort. They
considered it as a tool to promote comfort during the transition period. When asked about
how they related to the dying patients, many participants said they wanted to treat all
patients fairly and gave the same amount of attention to each of them, despite their
background; however, they would try to relate themselves to the patients at a personal
level by their ethnic background, age, and other factors to act empathically during the
dying process.
When asked whether or not they were scared or felt uneasy about patients dying, the participants mentioned positive experiences to counter any suggestions that they might fail to cope in the moment. As an example, Philip said:

I remember him [the patient] dying or trying to die, you know how they do that [participant models deep breaths] guppy breathing, um, or agonal breathing as we call it. So this agonal breathing, working really hard, and they have that, that horrible sheen to their face, when they’re sweating and working, working so hard and um, I think this was back in the day when they didn’t give a lot of analgesia. I can’t remember what he was dying from, and um, and then, he died. And my first thought was, and I know it sounds particularly esoteric, but ‘My god, they really do look like they’re resting, they really do look like they’re finally at peace’. He wasn’t working hard, I mean, he wasn’t struggling for breath. It wasn’t like he was struggling anymore. It was more like he was OK. He was fine.

Many participants stated that their most memorable experience was caring for their first dying patient. Many agreed that their level of experience greatly affected their competency and comfort level during the dying process. Mark also compared the suffering of his patients before they died with the peace they seemed to show after they passed away:

I, uh, see peace, like before they die . . . , you know, a lot of pokes . . . , lines, tubes, and everything like that. And when they die, you know, then we clean them, they look peaceful, so I guess they’re at peace when they die . . . And sometimes, I talk to them, ‘may you rest in peace, mister’ like this . . . , I think it’s very important.

Overall, most participants described taking care of dying patients as an emotional experience and they felt sad to see their patients die. The participants generally described how providing comfort care to patients was part of their job and indicated they had no difficulty fulfilling this role.
Changing the Focus From Patient to Family

In the course of providing comfort care to dying patients, the family was a significant consideration. Family typically experienced sorrow that their loved one was dying. Family members encountered various emotions, such as sadness, anger, regret, guilt, and uncertainty. Participants indicated that supporting the family through this transitional period by taking on their anger, emotion, and blames was challenging. Most participants mentioned that when the goal of the care plan changed from active resuscitation to comfort care, their focus shifted from the patients to their families. Henry stated:

So you have to shift your focus somewhat, you’re still doing all your basic requirements at the bedside, but your focus may shift more from the actual patient on the bed which you are still maintaining, but to that of sensitivity and encompassing the whole healthcare team, in dealing with the family, and how best to make the experience for them.

During this period, participants had to juggle between patients and their families, and had to take care of their physical and emotional needs. Hegemonic masculine ideals suggest that men are stoic and less expressive than women. In keeping with these ideals it was apparent that many participants had to maintain a balance between fulfilling a task (i.e., assessing the patient, giving sedative and analgesia infusion) and offering emotional support to the family. This participant, Henry, perceived that supporting families during their transitional period was a shared load among the professionals in the healthcare team, rather than solely the responsibility of nurses. Supporting families as a team helped to fulfill their needs in different ways to promote the best experience for the families in an emotional situation.

Several participants indicated that providing comfort care for patients was “straightforward”, because they had the medications and other tools to aid the dying
process for patients, and therefore, taking care of the family became their focus. Jacob explained:

I feel relatively confident that I can take good care of that dying patient in the ICU because I know I have the tools to do that, I have the, like the infusions, I have the bed, I have all that kind of stuff, so really, I’m at the point now that my first thing is family. Because I know from experience that once I have my comfort care orders and everything all set up, the majority of my time would be dealing with the family. You know, and it’s gonna be about them. Really, because in many ways, that person, that the patient part has already been taken care of.

In the above quote, Jacob suggested that male ICU nurses see their job as a task. Moreover, caring for the patients and families required confidence and the tools and medications that were used allowed Jacob to gain control and assurance during the process. Similarly, many participants reported that they could “objectify a dying patient” by focusing on different tasks instead of the patients’ or the families’ needs during the process. Consequently, to avoid that happening, Henry suggested that it was important to encourage the family to get involved and share the experience with the patient:

I often have in the past suggested to family prior to the actual withdraw, you know if they like particular types of music, bring that in, photographs, talk to them, if they like books or literature, read to them, treat them as though they are as they were before. And, um, because I don’t want to objectify a patient, I want to keep them as real, and the experience as positive as possible, because I think again, you’re, unless they’re an unknown patient, unknown X or number 1, there’s almost always family involved and there’s always different family dynamics. It can be quite dysfunctional, and challenging, and difficult, but on the whole, it’s not. So, just focusing on the family’s needs.

Many participants suggested they were task-oriented, and looked for positivity and tried to maintain stability in the face of potential chaos. Inviting families to bring in music and photos allowed participants to better understand not only the patients but also the families and to offer holistic support during this difficult time.
Many participants focused on providing a positive experience for the family, and they considered that fulfilling the family’s needs was more important than strictly adhering to the rules or policies of the unit. Bob shared:

They [families] are sort of in an emotional and vulnerable time, and we’re approaching them for organ donation. Um, you know, try to facilitate around our rules of not, it’s 7:30, not visiting and that sort of [rule], well, I’m sorry, your son is dead and is going to be going to the operating room in an hour or two for organ retrieval and all that. I don’t really care about that sort of rule, you know.

Bob positioned himself as an advocate and protector, who knowingly broke the rules to attend to the needs of the patients’ families. Similarly, Philip explained that providing holistic care for both the patient and the family “trumped” unit policy; in sharing a poignant and powerful story:

She [wife of a patient] didn’t sleep at her hotel so she came, and we moved him [the patient] over, made sure that he was clean, you know, moved him over, and she crawled into bed. You know, the beds are so tiny, turned him on his side and with his floppy arm, put it across her, and she fell asleep, and she said that it was, I guess she slept for like two hours, and she just was out, ‘it’s [the] best thing through the whole thing’ she said . . . So that’s what I mean, you know you, you can’t follow the rules. You know, the no pets, the no whatever, whatever the rules are, this is what they need. This is what they need.

Philip provided another example of how he fulfilled the request from a patient’s mother when her son died:

When I say that I do whatever they [family] need. The mom whose son was in this awful car accident, flipped his car, and he was in an anoxic brain injury from drowning, and um, she crawled into bed with him, and had his head on her chest so that when we pulled the tube [breathing tube], she could hold him as he died.

Philip was able to see the ultimate needs of his patients’ families. He identified not just the immediate need of the family—a mother wanting to be there for her child—but also the lifelong comfort for the family, a lasting memory for the mother that she
could hold her child on her chest before he passed away. Philip’s actions suggested that men could be compassionate and caring. This also indicated that men were assertive, wanted to be in control, and that they were not afraid of breaking rules. Besides being present with a patient and carrying out requests of the family, the participants mentioned the importance of being empathetic about what the family was going through. Philip put himself into the patient’s or the family’s position as a means and measure toward understanding their needs:

When it boils down to it, it’s just all a job. You have to be able to do your job, but part of your job is to let yourself, or be emotionally there for them, at least to be understanding to them, to be empathic. You know? It’s a learned skill . . . , I think people can have it but they don’t know how to hone it.

Philip embraced the emotional work of the job as a means to providing empathy. For the participants, doing their job well was a priority, and part of this involved attending to emotional needs of others. When asked about the challenges of taking care of the family of a dying patient, many participants said that knowing the family and their coping mechanisms was the key. Facing unpredictable reactions from families round the death of their loved one was a challenge. Jacob recalled his feelings when he was assigned to care for a dying patient:

You know when I was a ward nurse, my very first thing would have been, ‘how is the patient doing?’ like you know, like, ‘are they awake?’ you know, ‘are they in pain?’ ‘what am I gonna have to do?’ When I’m in the ICU honestly, I’m being very honest, my very first thing would be, ‘What’s the family like?’ ‘How is the family doing?’ ‘Are they crazy?’ ‘Are they coping well?’ . . . because that [the family] is the unknown.

Taking care of patients’ families could be stressful because their responses varied and were out the participants’ control. Unable to predict or control these situations, the participants were vulnerable and could not always take the lead. Mark suggested that
nurses need to know the family’s coping mechanism before trying to support them.

Moreover, he believed that nurses needed to be flexible and sensitive during the process:

It depends on the family members as well you know . . . I notice they have different coping mechanisms with regards to dealing with death and dying. Sometimes, they just want to be left alone, and I respect their boundaries. I keep boundaries as well. Sometimes, I notice that they want to open up, talk to a nurse, and I make myself available if they want to talk, whenever they want to talk.

Mark was able to see himself as a supporter instead of the leader in the course of caring for dying patients. Being able to set healthy boundaries and distancing from the families could avoid participants from burning out. Mark had total confidence that he was able to identify the families’ needs and coping strategies, and he was able to empower families to deal with their own emotions and independently seek help whenever they needed. Mark gave an example of how he provided support to a family member by listening and being there for her. At times, the family might be difficult to handle, with shouting and blaming, but he insisted that being empathetic to what the family was going through and understanding their unique reactions as coping strategies were essential:

And when the patient died, she [patient’s wife] cried and she embraced me . . . I was there at her side when the patient died. And you know, I know that the faces of dying, I understood that. I never talked back. You know, I just listened to her, and she embraced me, and she was crying. So, it’s um, makes it more aware that you know, when the patient [family] shout at you, it’s their normal process of grieving, and you know, I find it, they are a very difficult family and really, really angry about the system at that time. . . . but for me, you know, I just stood there and listened to her. I accepted all of her shouts and everything, you know . . . I totally empathize with . . . [her].

Mark was a supporter and comforter for his patient’s wife at that moment. Some participants said that offering support for the family was more than just a job, but it was all about the relationship and care that a nurse should give. Several participants reflected on the memory of the final moments that a family had with their loved one. Some
participants asserted that they could create a positive memory for the family during such a vulnerable time, as Carl expressed:

I try to turn the negative into a bit more of a positive, and be like, it’s really special that you get to be here with their loved one as they’re passing, and you know that a lot of people don’t get that opportunity when someone’s dying in an accident or in the middle of the night or something. So it’s actually like, I try and bring out more of the positives in it. You know, like an end to, um, some suffering that the patient’s experiencing, or, that, it’s OK, it’s their time. You know, yeah, just trying to make them feel encouraged a little bit in that they are gonna be a part of it.

Many participants demonstrated a positive and cheerful attitude about life when sad situations arose. Carl presented his ability to be strong for the family and comfort them in a demanding situation, which exhibited the masculine ideals of strength and being the ‘sturdy oak’ for the family to depend on or lean against when necessary.

**Being Emotionally Attached**

In seeing patients die and how the families dealt with the situation, some participants mentioned that they sometimes became attached to their patients. These attachments could be intense, depending on their relationship with the patient and family. Leo asserted that this was acceptable, amid addressing the significance of boundaries and self-awareness during this process:

I think I always have a little bit of emotional attachment. I think it’s OK to do that. Um, I don’t want to be that cold type of nurse I call them, just very cold hearted and um, I think it’s OK to have a little bit of emotional involvement but just know your boundaries and be self-aware of what your triggers are, why you’re connected, why you’re feeling invested.

Keeping a healthy boundary was a self-protection mechanism, whereby participants avoided being too involved when caring for dying patients. Several participants thought that being with their patients when they died was an intimate
encounter, and believed that human touch and presence, and the comfort they offered during their passing was essential, as Carl stated:

Physical touch is important at that point. I always want to hold my patient’s hand. When I come to see them, I just want to like put my hand on them and . . . I want to give them comfort as they’re passing, and know that they’re not alone, so I want to, lots of times they’re not looking around or anything, that they could still feel my presence there if I like put my hand on their shoulder or holding their hand, or um, I will talk to them.

Many participants believed that offering comfort and being present for their patients was important. When talking about supporting patients through their transition to death, most participants were adamant that patients should not die alone. Bob even promised himself that he would not let his patients die without their family, friends, or himself being present at their last breath:

I promised myself many years ago that if I have the ability, my patients aren’t gonna die alone. You know, so if they don’t have family around or friends and all that, I will, you know, ensure that I am present . . . particularly for their clinical last breath.

Many participants showed that they were able to embrace being emotionally attached after witnessing their patient’s death. Some saw it as part of their nursing duty and challenge in the ICU, but it also illustrated their ability to cope, even with a certain level of connection with their patients. Moreover, this showed the masculine norms that they tended to be strong for people around them and, in this case, for their patients and their families.

**Trigger Points**

Several participants shared that they were emotionally attached to the patient and family when caring for them during the dying process because they reminded them of their personal past experiences. Some participants referred these experiences as their
trigger points, in that commonalities such as ethnic and family backgrounds led to an emotional closeness to the patient:

Like I said, you know, I don’t know why I sort of teared up with the family there, you know, it’s sometimes, you know, there are triggers . . . It reminds me of my sister, you know, reminds me of my dad, you know, probably more so.

Many men who participated in this study experienced sadness, though they were reluctant to express this feeling through tears. Most participants stated that when they cared for dying patients and their families, they thought of their own mortality and/or their loved ones. They tended to reflect and naturally connect themselves to the patient’s situation. Therefore, when asked about how they felt about the triggers in the course of taking care of dying patients, Vincent related his feelings to a sense of weakness:

I try not to think, because I have that one experience with the trigger point, you know, I really didn’t like that feeling because I couldn’t really function. I couldn’t function. I had to go away for about five minutes to kind of pull myself [together]. I think, it happened one time, I didn’t like . . . , I still make sure I don’t let that happen because it affects the job . . . , I don’t like things to affect my job. I’m the one that needs to make sure that things are OK. The one word I really should use is ‘vulnerability’. At that time, I felt very vulnerable. I didn’t like that.

For Vincent, in order to get his work done, he purposely did not show his vulnerability and chose to take refuge, a five-minute break, to help redirect his focus back to his work. The work was the participants’ priority and enforced their identity. Being disturbed by their emotions, especially “vulnerability” at work was to be avoided. Many participants would not permit themselves to show their weaknesses. It certainly made them feel like a failure if it happened.

Some men tried to place barriers between their work and personal lives. Timothy indicated that his work life and his family life were two distinct entities and that he did
not allow his job to affect his emotions, because his patients were not members of his family:

> It’s not my family member. I have no direct relationship or connection with [the patients]. Um, I can feel sorry for what the family is going through, um and I can offer what comforts I can, but do not become emotionally attached.

Drawing on masculine ideals, Timothy, and some other participants, indicated that they were able to handle the situation. In addition, objectifying and depersonalizing themselves from the events appeared as a strategy to ensure self-protection in order to maintain their well-being.

**Shedding Tears**

Many participants indicated that they could feel the pain of the patients’ families during the dying process. Some participants also shared that when they were emotionally attached to the patients and families, they sometimes cried at the bedside, which was considered as a way to cope with their sadness. Despite attempts to be stoic, several participants, including Jacob, mentioned that they sometimes cried at the bedside, after seeing their patient die:

> I don’t ever recall crying this much at the bedside as I did on this one. Yeah, so, it was a tough one . . . My response was, because . . . it was such a tragic story for her [the patient], well, I . . . , as nurse, we’ve heard tragic stories all the time. But it was because the family was so, I was so moved by the way they were coping with it. I have never seen people cope that way. I’ve never seen people cope with tragedy with such an outpouring of generosity and love, and it was so moving. That’s really what got me.

Jacob cried at the bedside as he was touched by the specific tragic circumstances, which assured that tears were an exception rather than a common practice for him. Even so, he did not contest his crying but rather expressed it in a healthy way. Traditional hegemonic masculine ideals describe men as stoic and inexpressive (Cecil & McCaughan,
2010), but most participants were unapologetic for their tears. Phillip, for example, indicated he had cried at his workplace, but looked at it in a positive way:

I think it’s OK to cry at the bedside. I don’t think it’s OK to sob. That sobby thing, I think that means you’ve lost perspective. But I think it’s OK to cry at the bedside with the family. I think it’s OK to bring it home because it’s been a long day, you know? It’s a long day when you, it’s exhausting, it’s an emotionally exhausting experience sometimes, and of course, you need some recovery time. I mean, for the most part, I’d leave the job, the hospital, but you know, there are some days, and it’s usually the dying patients that I’d take home with me. But I think to myself, when I do that, I think I did a good job. You know? I did a good job with the family. I did a good job with them. You know. I made it easy for them, to say goodbye and to be that patient advocate.

Expressing emotions, such as crying, may be thought of as unusual for men. However, Philip suggested that crying in a manly professional way without losing their perspective of their job was acceptable—differentiating it from sobbing uncontrollably, which was improper for men in general as well as male nurses.

**Staying Positive**

Many participants indicated that the fact that they frequently saw patients die led them to see death as a positive thing, whereby death was just part of living in that no-one could live forever. Being able to accept death helped them to cope with the stresses that arose when caring for the dying patients. They believed that working as an ICU nurse equipped them to face death, as Jacob confirmed:

Well, before I was a nurse, I had no experience with death at all, like I think most people do. Um, believe it or not, I would have to say, it affected me in a very positive way in a sense that, certainly, before I was a nurse, I feared death. I have no fear in death whatsoever now. None. I’m not scared of death at all . . . , and I’ll tell you why, because I’ve been in the room. I’ve been in the room where people died. I’ve held people when they’ve died. And, it’s a wonderful thing.
In witnessing death, Jacob engaged masculine ideals that expect men to be courageous and strong; he appeared to rationalise the situation to make peace with it. Some participants suggested death was only a temporary separation, something spiritual and transitional, while others thought that death was a biological and psychosocial end.

Many participants said that working as an ICU nurse had changed their perspectives about life and that they began appreciating life more after seeing patients die. Some were grateful that nursing had allowed them to see the fragility of life and they were learning to prioritize the importance of things in life. Jacob expressed his appreciation:

I think working in this environment, it should make you the best person on the planet, because you should be so aware of how precious life is . . . It certainly has changed the way I prioritize what’s important in life for sure.

Participants reflected on their lives, and appreciated their family and friends. Several participants mentioned that, after witnessing their patients’ death, they learned not to get irritated by unimportant things in life. Jacob also referred to the “deathbed question” to describe what he meant by setting priorities in life. He stated:

Well, I have this thing, this thing that I do now, I call it my ‘deathbed question’. By that, I mean, what are you gonna do on your death bed? For example, I was talking to someone who works here, a good friend of mine, and we’re talking about doing overtime, and you know, she’s doing a lot of overtime, she’s totally burnt out, she’s miserable, you know, all her relationships, you know, everything is suffering because she’s burnt out from working too much. I said to her, I said, ‘Look, it’s a deathbed question. When you’re on your deathbed, are you gonna say: ‘You know what, I really am so happy I worked all that overtime and I wish I worked more?’ Seriously. No, you’re not. You know what I mean? You’re gonna say, ‘What was I thinking? Here I am, you know, I’m in the prime of my life and I’m making myself miserable for what?’ So, that’s how it’s affected me. Yeah. For the better.
In Jacob’s assertion, he advocated living and enjoying life, suggesting the unpredictability of death as the trigger to embrace that. In this respect, staying positive was also applied to guide the lives of the workers in the ICU. Seeing patients coming in and going out of the ICU, the participants started to note that life was more than just work. They now realized that life included various components (i.e., better health, relationships, etc.) that they treasured more. Most participants stated that they appreciated their families more after seeing trauma victims die in the ICU. Several participants said that they did not want to live regretting that they were unable to tell their loved ones how much they loved them. Philip gave an example:

I think that it’s important that you don’t live your life with regrets. I mean, no matter how cranky I am with my significant other, the last words that he hears as he leaves the house are still, ‘I love you’. You know, because, God forbid, he should be hit by a bus or something and the last words that he heard were, ‘Oh my god, you left your socks on the floor again!’

Most participants realized that they should enjoy life more because life was so unpredictable. Carl, for example, indicated that life seemed to be random and short, and he wanted to live it. Having said that, he found himself struggling between the extremes of enjoying risky activities and being afraid of dying young:

Uh, like, I ride a motorcycle, I snowboard, I have a couple of activities that are a little bit on the dangerous side and uh, in one aspect, it makes me feel super cautious, like riding, especially in riding motorcycles. I feel like a little of the fun is taken out of it. And I’m a little bit, I feel paranoid if I’m gonna wipe out and just the repercussions of all that. You know, at the same time, it also makes me want to be, I don’t know if it’s the right word, ‘crazier’, because who knows when my heart’s gonna get pulled. You know, I feel like, ‘OK well, this is life and it can end whenever, so I need to live it and live it, not live it large but like just really do life right now’. you know? So it’s a weird, it’s a weird pull between feeling like extra cautious and almost worried about what could happen to me, and just wanting to go and get free, and just do everything, and just live now because you don’t know how long you’ll get to live, you know?
Carl’s involvement with risky activities aligned to masculine ideals; however, Carl, along with several other participants, mentioned that they were more aware and cautious about risk-taking after working in the ICU, especially in terms of wanting to prevent accidents. In this regard, caution and conservatism tempered many participants’ alignment to risk-taking, but enhanced the desire to appreciate each experience and day.

In contrast, Timothy stated that he saw work and family life as two discrete units. Seeing patients die in the ICU did not change the way he perceived life or how much he appreciated his family. Timothy said:

I try to live my life and treat my family the way I would normally treat them. I love them every day. Just because a patient died, I don’t go home and hug my kids any tighter or longer than I would any other day, right? My work and my home life are two completely separate entities.

In this example, Timothy asserted his focus on separating work in denying that it changed his ‘other’ interactions. Drawn upon are masculine ideals that compartmentalize work and home, amid assurances that death does not impact who he is at home.

**Stress and Coping**

Significant stress can impact on ICU nurses during a patient’s dying process and participants coped in a variety of ways.

**Sources of Stress**

During the course of caring for dying patients, many participants mentioned that moral distress was one of the sources of their stress, highlighting how patient advocacy was difficult when informing the doctor that a treatment was prolonging the patient’s death. Moreover, some participants indicated that some doctors’ apparent lack of interest or knowledge about the course of dying was stressful, as stated by Philip:
A nurse is a patient’s advocate, and a lot of times, our paths [with the doctor] are similar, they go on a similar direction, but then, a lot of times, our paths are sort of . . . we butt heads, I think that doctors, it takes them forever to make the big decision to say ‘no’, ‘no more’, and yet, I also think that for nurses, . . . I think we can be quick to say, ‘that’s too much for this patient, and we should switch to comfort care’.

Participants worked within an interprofessional team at their workplace, and often times took the lead to advocate and provide for their patients, and spoke up to persuade others with their viewpoints. Besides having some conflicts within the medical team, caring for the family was also a source of stress, and several participants said that some families projected their anger toward nurses. Carl observed:

When a family doesn’t agree with, you know, hasn’t accepted the fact that their family member is dying. And instead of . . . dealing with it, they kind of like, project that onto you because they’re angry about the person passing away, and um, you’re the person there, you’re the outlet almost in a way, and so that’s why a lot of their frustration gets directed towards you, which I find makes a really, really hard situation.

Some participants felt vulnerable and frustrated in being blamed and misunderstood by the patients’ families, for they could not fight back. As professionals, they seemed bounded and limited in this situation.

When participants were asked to give one or two examples of their most memorable stories about a dying patient, most told stories of their first dying patient. Experiencing fear and uncertainty, they found that this was one of the sources of stress during the process at the time. Philip recalled his feelings when caring for his first dying patient:

But I was really, ‘Oh my god! Oh my god! It’s my first dead body! It’s my first dead patient! What am I gonna do?’ Really, because nobody remembers to tell you this in nursing school, they never . . . nobody ever tells you how to deal with it in nursing school. I mean, I can thinking how scared I was, how I’m going to react to what’s going on, and whether or not I was going to be all right in doing this.
Philip’s reaction suggested a vulnerable feeling and counters the hegemonic ideals that men are supposed to be strong and in control. As a new nurse, Philip lacked experience regarding how to care for a dying patient, which increased his experience of stress. Failing to cope with their duties certainly heightened participants’ stress levels and affected their confidence. Nevertheless, through gaining experience from caring for dying patients, participants’ stress levels could reduce over time.

The sources of stress emerged from disagreements with medical team members, volatile families and/or the nurse’s inexperience with death. In turn, participants described an array of coping strategies to prevent burnout.

**Coping Strategies**

The coping strategies used by the participants varied. For example, Henry used the term ‘being hardened’ to describe how he was desensitized by his experiences, after working in the ICU for many years:

> Because you see so many things over the course of a career, and I’ve been nursing for . . . years in critical care. Uh, there’s that term ‘being hardened’ and you, I think, again, it’s a protective mechanism . . . a defense mechanism, and you need to do that. It’s not as though I don’t care about anyone. It’s just the exceptional ones that are unique or bring me closer to the patient and their family, when you get to know them.

The accumulation of experiences in caring for dying patients enabled participants to sharpen their competency and reduce their stress level. Being touched or impacted by death became the exception for Henry. Time and repeated exposure had led him toward self-protection; a strategy he now purposefully employed in his work.

When asked how they coped with stress, most participants said they tended to talk and share their feelings with their nursing colleagues. Many, including Philip, also said that through talking with their colleagues during report at shift change they felt that they
were being heard and their burdens were lightened because others had gone through similar struggles:

I learned that you, if it’s a weight that you’re carrying, in order to decrease that weight, you need to give it to a bunch of people because it’s easy to share a burden by talking about it. And each time you talk about it, you share a burden of it, you share a part of it. So, everybody gets to carry it and it’s not so heavy if there’s a lot of people carrying it.

Masculine ideals, including stoicism, can render many men reticent to share their emotions and feelings. In contrast, many participants suggested they liked to talk and share their frustrations with their nursing colleagues to dissipate their stress. Conversely, some participants also said that it was hard for them to share their feelings and talk about their experiences with their non-nursing friends or their family, because others did not understand what they went through at work.

Besides sharing their feelings with people they trusted, many participants mentioned that they used distractions to relieve their stress. These included watching TV/movies, hanging out with friends, and the use of humour. Chuck gave an example of how he reduced his stress:

Sometimes, we do go out for drinks after a really bad shift and um, I think that’s when it’s a particularly very bad day, then we get a very good cross-section of everybody going out [laughs]. It’s not always the best coping mechanism but we spend time together, then I think which is sometimes a good way to decompress and it’s probably for team-building as well. Um, not the healthiest, but it works.

Having a drink together was a helpful way to help reduce stress, as well as the intensity of the bad day. Many participants mentioned that alcohol consumption and partying were the long-held rituals in nursing in the ICU. They managed stress by spending time and doing activities with their friends and families, for they needed that ‘kinship time’ with their friends to help them balance their lives.
Some participants also mentioned using humour as a distraction, indicating that it helped them to ease the intense work pressures. Henry said that he often used black humour to lift the mood:

It’s a known thing that nurses have black humour. And it may not be about that patient, but you have to find some release, so you may have black humour . . . Yeah, you have to, and it’s a form of camaraderie and it also brings your peers together.

Some participants also used humour, such as teasing, to reduce stress and regain their positive viewpoint in life. Humour could lift up mood, but some participants mentioned that it was not applicable in all situations, based on the condition of the patients. However, appropriately used humour sometimes could draw peers together and ease the intensity of a bad day.

Participants also relied on healthy lifestyles to relieve stress. Specifically, a healthy lifestyle included doing something that they enjoyed (like cooking/baking, playing chess, soccer, or photography), spending time with their family and children, exercising and doing outdoor activities, going on vacation, sleeping, and praying. These coping mechanisms seemed to be helpful, as Luke explained:

I guess you just try to maintain a healthy lifestyle or just do the things that you enjoy doing, like not having that to stop that . . . If you exercise every day, if you run three or four times a week, you try to keep that the same, and to have um, a balanced lifestyle. I sleep a lot. I find that nice and to me, I think to be able to have good rest, about 12 hours of sleep . . . it helps!

Idealized masculine activities include the development of meaningful hobbies and relationships with families. Many participants perceived being active and doing things that they enjoyed simultaneously aided their well-being and reduced their stress levels. Adam described his contentment in spending time with his children after a long day at work:
I’m sure a lot of our nurses here have kids too, you know, their kids relieve their stress, and my 3-year-old son will kiss me in [on] the cheek and I’m OK. A lot of uh, I’m sure a lot of our nurses are like that as well. Their kids are their source of happiness.

Besides gaining benefits from a healthy lifestyle, a few participants mentioned used counseling services to counter high levels of stress. Leo explained that he had a strong feminine side:

Me personally, I’m kind of a mommy’s boy from when I was a kid, so, I think I have more female traits than male traits when it comes to my emotions, um, my wife’s completely aware of that. I cry like a 5-year-old girl every now and again, and that’s OK . . . Um, I don’t see a problem with that. Um, I think it’s probably worse if you just kind of keep it in and it just keeps building up and building up, at some point, something’s gonna give. So I think, this kind of release in the pressure cap every now and again, is OK.

Traditional hegemonic masculinity suggests that men are stoic and are not expected to cry, but Leo revealed that social expectations of masculine ideals covered up the true feelings and needs of men. He saw crying as a way to quell his stress and, by doing so, he abstained from masculine norms and ideals in order to maintain his well-being.

Participants were asked if they thought male nurses were prone to burnout at their workplace. The majority of them felt that burnout was not necessarily more correlated with being male, though burnout was connected with their ability to cope. Isaac said:

I think it has to do with personality and perspective on life, and if you’ve got something outside of work, if work is your only focus, and you’ve got no extra-curricular activities, there’s no volleyball, there’s not ice skating, skiing, then I think you’re more likely to burn out. But, I don’t think that has anything to do with gender.

Many participants saw work–life balance as the remedy to avoid workplace burnout, and they also believed that coping with stress in the challenging moments at work was key. Jacob said:
I think any nurse who’s successful in this environment is gonna have to have some ability
to deal with stress because it’s very stressful [to work in the ICU] . . . And if you can’t deal
with it, you’re gonna be miserable here. So yes, they have to [deal with stress successfully].
Well, some are better than others, but they have to, you have to be somewhat competent
dealing with stress to be successful working here.

Jacob, in detailing stress management as a requisite to being effectual in the ICU,
was clear that one needed to be resilient and cool under pressure to succeed.

In conclusion, stress and coping strategies often go hand-in-hand. Participants
understood that they might not be able to avoid stress in their workplace, but their ability
to cope with it would significantly affect their work performance, patient care and
ultimately their life quality.

**Supporting Male ICU Nurses in a Female-Dominated Environment**

As a minority gender in the nursing profession, some participants agreed that
society and other healthcare professionals were biased toward their abilities. In this
section, how male ICU nurses considered themselves in a female-dominated profession
when caring for dying patients in the ICU will be explored.

**Stigma**

The term stigma was used by many participants to explain what it was like being a
male nurse caring for dying patients. Alan referred to how some families were biased
against him, suggesting that female nurses were more caring and better able to understand
the feelings and emotions of others:

I think most traditional families . . . in Canada we have a lot of them, they feel more
comfortable with the female because they think that maybe the females have a better
understanding of their emotions than a male does. That’s my opinion.
Several participants suggested that patients and families were more receptive to female nurses because they were more sensitive and caring. However, participants believed that they were as competent and caring and did not see themselves as operating differently from the female nurses when caring for dying patients. Indeed, a few participants argued that some female nurses were strong and independent; Henry stated that some female nurses were ‘tougher than nails and can probably beat them [male nurses] up’. Bob believed that the care he provided was valid and competent, and equal to the care given by the female nurses:

You know, men are equally capable and able to provide that support and care to family and patients at the end-of-life. As ah . . . you know, people tend to think that it’s not a man’s thing. So, and it was, you know, probably two points, valid because men can also do it, but also valid, you know . . . um . . . I’ve always been confident with the care I provided . . . there’s validity in that.

Bob suggested that people tended to believe that caring for dying patients was a female’s job, but he insisted that it was not. As reported by other participants, he trusted that gender would not affect the quality of care he provided to his dying patients, and suggested that some patients and families appreciated his care because of his competency, work ethics, and kindness—not his gender.

**Supports at Work**

As a minority gender group, participants sought various supports at their workplace when caring for dying patients. Most participants suggested that they worked collaboratively and helped one another. However, many addressed their preference of sharing their feelings and emotions with male, instead of female, colleagues to cope with stress and maintain their masculine ideas after seeing their patients die. Some expressed that they needed colleagues from the same gender to make jokes with, share laughter, and cope with difficult times—for male colleagues understood their emotions better than their
female colleagues. Isaac recalled what he had seen at his workplace and the spirit of kinship that was present:

Um, I think the boys, sort of have a little camaraderie, among ourselves, you know supporting ourselves, but I don’t think . . . like when you look at [male nurse 1] and [male nurse 2] . . . , they are huge pranksters, particularly among themselves. Um, doing a lot of pranks whether it’s locking somebody’s locker with a lot of plaster of Paris, or um, just pranks like that. I think that there is a little bit of a kinship.

The mischievous connections among the participants described here gave rise to a cheerful workplace. When asked about their relationship with their female colleagues, several participants said that although they received support from their female colleagues, the male–male emotional support was important. Alan explained:

They [the female nurses] like me professionally and I have friendships with most of them. Um, and I like them as well as my colleagues . . . But, you need, as a human being, your own gender sometimes in order to cope with other things in life. I don’t know if I can make myself more understandable, you need to be with your own, like males, in order to make a joke, feel like, let it out. That’s all.

Many men handled stress by spending time and doing activities with their families and friends outside of work. The kinship provided them with a sense of belonging and support. They needed friends to laugh with and to understand their struggles. Several participants indicated that the more male nurses at their workplace, the better the dynamics. Jacob explained:

I think one of the reasons why I enjoy the ICU nursing so much is because it has the most male nurses in it. I’ve never, in all my other nursing jobs, they were predominantly females. I’ve never worked with so many men here. And it has been my experience that . . . the more gender mixing there is in the workplace, that the happier it is.
Most participants agreed that they were well supported by their female colleagues at work. At the same time, they also appreciated the relationships with their male colleagues and drew support from them when challenges arise.

**Being Acknowledged at Work**

Most participants agreed that the gratitude expressed by patients and families was one of their sources of happiness. Thank you cards, letters, hugs, cookies, little gifts, and mentions in obituaries, and both the verbal and nonverbal expressions of appreciation helped participants to feel good. Adam recalled a time when his patient’s family returned to the ICU to thank him personally:

> I looked after a patient in . . . [one side of the unit], I remember, and the wife came back, I didn’t really recognize her because of, it’s been a while. But eventually, when she told me who her husband was and what happened and all that, I remembered, and she embraced me. Um, that was really good.

A few participants mentioned the validation provided by family members in recognizing them as an integral part of the healthcare team. Henry elaborated, recounting the feedback from a patient’s family member:

> ‘Wow! Nurses are an integral part of what really happens in critical care and nursing’, and then they’re very appreciative. ‘Oh wow, I thought you guys just dispense meds [medications] and bedpans, but there’s so much more you do, and you’re always around, and you’re so caring, and so thank you’, you know, and so, that’s kind of nice.

Besides the gratitude expressed by patients and family members, the doctors’ shows of appreciation also meant a lot to some of the participants. Henry said:

> You know. Its [nursing] often a thankless job but it’s really nice, the small times, if the unit’s super crazy, if the doctor or the intern says, ‘Hey, you did a great job!’ All that adversity, and you get that little pat on the back. That means a lot.
These two examples illustrate how participants responded to positive acknowledgement and affirmation, which in turn boosted their intrinsic job satisfaction.

When asked whether or not it was important to be happy at their workplace, most participants felt that it was crucial. Some participants stated that ‘happiness’ seemed to be general, and better replaced by other terms like: satisfaction, sense of purpose, productivity, value, pride, or joy. Vincent recalled the times when he was happy at work, and he went home with a smile on his face:

I like to go into work being happy. I just stay happy at work. And I can tell you, those days that I’m happy at work . . . those days . . . I’ll go home and still be smiling. Even though after 12-hour shifts, sometimes I’ve done . . . I’ve done 16-hour shifts, over time, and I go home smiling because it’s actually a good day. So, being happy is good.

Similarly, Chuck summated that if the work of nursing did not provide such benefits, the job was untenable:

I think you need to enjoy your job and I think you need to enjoy your colleagues, and be happy with what you’re doing, and enjoy the work you’re doing, or yeah, it’s just not, I think, you know, there’s so many things we can do with our careers and so much, so many different avenues we can pursue, um, that if you don’t really love what you do, really enjoy it, um, it’s not worth it really, because you will get burnout then. I think those things, things will get to you in the work environment that um, will challenge you. So I think those um, I think if you don’t like it anymore, that’s the time, you know, to move on.

In this respect, participants indicated that their job was one place where they could find happiness. Most participants were satisfied with their job and providing care to those in need. Afforded benefits beyond paying the bills, a deep sense of satisfaction and validation in working in a female-dominated environment was also crucial.

Many participants related job satisfaction to the quality of patient care, suggesting that being happy and satisfied at work and in their personal lives would positively affect
the way they treated their patients. They also felt that if they were not happy at work, they would not be able to show their full potential and would burn out faster. Henry suggested:

We all have good days and bad days, but the quality of care would be directly influenced by our degree of happiness. Of course, and I think, on purely a core level, if you’re happy, um, that will directly relate to your ability to perform better at the bedside. You’re more tuned to your environment. You’re thinking on a clearer level, your skills are more pronounced, you’re perceiving things and more attuned to everything.

From the participants’ perspectives about comfort care, Bob thought that when nurses were positive and happy, they could best support the patient and families through challenging circumstances:

It just helps you be present too; . . . for particularly when we’re talking about the context of end-of-life care. I think being happy or you know, generally, in a good mood, helps, you know, um, you know, you’re not bound down by emotional things so you can be present to sort of provide that support and care to patients and the families.

Overall, positive acknowledgment from patients, families, and other healthcare professionals reassured the ability and the contribution of the participants at their workplace. Recognition of their performance enhanced job satisfaction, which positively correlated with the quality of patient care. Moreover, intrinsic satisfaction about their job allowed participants to fulfil their potential and do their best at their job.

**Summary**

Male ICU nurses often take care of dying patients at their workplace. During the patient’s dying process, many participants felt that it was the patient’s time, and they had a ‘no pain and no fear’ attitude to provide the best for their patients. They also experienced stress and vulnerability at times, but they learned to deal with it by using various coping strategies. Many of them would openly share their feelings and even cried at the bedside to express their emotions, which appeared opposing the traditional
hegemonic masculine ideals. Their support for the patients and performance at work induced biases as well as acknowledgment from patients, families, and healthcare professionals. Male ICU nurses’ contribution gave them pride, job satisfaction, which positively correlated to quality patient care at their workplace.
CHAPTER 5: DISCUSSION

In this chapter, I discuss the overall findings, connect them to the existing literature, and discuss how male ICU nurses maintain their well-being and sustain their masculine ideals when caring for dying patients in a female-dominated environment.

Masculinity in Relation to Comfort Care and Male ICU Nurses

Working in a female-dominated environment, participants expressed and embodied their masculinity in various ways. Most participants spontaneously acted as caregiver and protector during the course of caring for dying patients and their families. Masculine ideals position men as breadwinners, providing the financial and material needs of their families (Oliffe et al., in press). However, participants also took up the role of protector and provider at work, especially when caring for their dying patients and their families. Men are also idealized as stoic, rarely talking about their feelings (Cecil & McCaughan, 2010); however, in this study, participants ran counter to such ideals, sometimes crying at the bedside and/or openly sharing their feelings with those they trusted. These masculine practices emerge in contrast to the literature addressing men and work, as well as the men’s health literature more generally (Cecil & McCaughan, 2010; Lomas, Cartwright, Edginton, & Ridge, 2013). Finally, from observing the dying process of their patients, participants reflected on their own mortality and life values, which in turn led some participants to reshape their lives and some masculine ideals.

Most participants stated that their primary job was to provide care and fulfil the needs of their patients. Some also reported that they would fulfil the needs of their patients and families, even when their actions resided outside the policies of the unit. Participants located themselves as providers in this regard, akin to Adinkrah’s (2012)
suggestion that successful masculinity is measured by the ability to meet the material needs and daily expenditures of others. According to Dyck et al. (2009), male nurses tend to take up the protector’s role and be more extroverted and assertive in taking the lead. This concurs with participants’ actions and accounts in that they gave priority to the needs of others and supported patients and families to minimize the suffering endured. Evans (2004) also indicated that for male nurses, being protectors “was a source of satisfaction as some… [male nurses] described feeling more valued, accepted, and appreciated, by hospital staff and women colleagues” (p. 17). While participants considered meeting patient needs as part of their job, the ways and means by which they did this both drew upon and ran counter to masculine ideals.

Pollak (1995) indicated that boys are taught to suppress their desire for love and connection and build a wall of toughness around them to be accepted as men. However, most participants expressed their emotions and acknowledged their fears or vulnerabilities when caring for dying patients and their families. Holding their patient’s hand, talking to dying patients, and consoling families led some participants toward being emotionally attached, which in turn gave rise to shedding tears and memories etched to such an extent that their own lifestyles and philosophies changed. Lomas et al. (2013) indicated that “emotionality is often feminized . . . [where] traditional forms of masculinity valorize emotional suppression, toughness, and outward strength” (p. 2). Counter to this, Brown (2009) argued that men can be empathetic and comfortable with intimacy, even though society tends to inhibit the development of these performances and emotional richness in men. The current study findings confirm that a plurality of masculine ideals and performances can be articulated through emotions and men’s expressions of those feelings. Some participants were insightful and articulate about their struggles and trigger points for stress, demonstrating an awareness of their emotional states. This finding
contrasts Cecil and McCaughan’s (2010) characteristics of hegemonic masculinity—to show little or no emotional sensitivity; in that, contextually, it seems completely reasonable (if not necessary) to be touched by death given the very nature of the participants’ work.

When asked about how they felt when they witnessed patients dying, participants suggested that they had learned to appreciate their life and articulate their care for loved ones more. Traditionally, men tend to internalize their feelings and act tough, which “involves suppressing, denying or disconnecting from feelings like fear and sadness, as well as not showing vulnerability” (Lomas et al., 2012, p. 8). In contrast, the experience of witnessing the dying and death of their patients led participants to reflect, value, and reprioritize their lives. Connell (1995) and Creighton and Oliffe (2010) indicated that masculine identity is reconstituted under the influence of what is adjacent. This caveat to masculinities was supported and illustrated by the findings that introspection and change came from caring for dying patients and their families. Death and dying, by influencing participants’ living also afforded some meaning and positivity from what were often tragic losses. Creighton and Oliffe (2010) suggested that masculinity adjusts and serves to reconfigure new perspectives toward life, after interacting with others—an important insight supported by the current study findings. Although participants aligned to some masculine ideals by showing their hardiness at work, they were deeply affected and often redefined understandings about their lives after observing patients go through the dying process.

Pollack (1995) stated that men don a mask of emotional bravado that leaves them isolated, whereby vulnerable, empathic, caring emotions, “get repressed and pushed down as a result of being teased or shamed” (p. 42). The current study findings suggested that
while participants drew on masculine ideals by taking up the provider’s role, they also unapologetically expressed their feelings, and reconstituted their identity through the care they gave at the workplace. Within a female-dominated profession, participants were able to mark their masculine identities, albeit in a variety of ways and means, some of which departed from much-cited masculine ideals of stoicism and self-reliance.

**Coping with Stresses at the Workplace**

In this study, various coping strategies were used by participants to deal with their work stresses. These coping strategies were pivotal to providing effective comfort care for dying patients and their families. Masculine ideals revere men as tough, cool, and able to deal with stress—most often through aggressive actions, such as fighting and/or engaging in risky activities (Connell, 2005). This study, however, revealed emotional toughness and resilience as key performances. Instead of stoicism, by sharing their feelings, crying, and developing a healthy lifestyle, participants were afforded respite to sustain their ability at work.

When asked how they dealt with stress, participants unapologetically stated that they liked to talk about their experiences and feelings with their work colleagues. According to Addis and Mahalik (2003), the popular stereotype of men suggests that they are reluctant to ask for help or to talk about their vulnerabilities with friends or families, but rather focused on protecting themselves and their masculinity. Counter to this, the current study findings revealed participants sharing their emotions and experiences as purposeful in helping to reduce their stress level. Participants’ talk prevented them from burning out and aided patient care. This finding is congruent with Oliffe (2005), who suggested that:
men have been able to challenge or reinterpret masculine ideals to find more constructive ways of relating to distress . . . [and they] are not inevitably emotionally disconnected, and can talk openly and insightfully about emotional experiences, even around sensitive issues. (p. 3)

Similarly, to cry at the bedside or cry in front of their colleagues or the patient’s family was understood as flowing from their empathy and care. While men are idealized as strong and stoic, and according to Brown (2009), “discouraged from the expression of grief and upset through tears, and encouraged to suppress emotion, except anger, and to ignore physical and emotional pain” (p. 123), participants drew on alternative masculine scripts. Likewise, men are encouraged to internalize distress and suppress visible emotions and avoid wailing, weeping or crying because it is regarded as an unmanly way of dealing with pain or loss (Adinkrah, 2012). In the current study, however, crying was not only a way to express their empathy and dissipate their stress, it could also reflect their masculine investment in being a provider and supporter. In this respect, crying at the bedside was not weak, but courageous, whereby some participants boldly expressed their emotions and compassion when caring for dying patients and their families.

Most participants reduced their stress levels through healthy lifestyles, including outdoor activities and diverse hobbies. In contrast, drinking and partying were also strategies for coping with stress. Lomas et al. (2013) indicated that hobbies seemed to be the most reliable source of contentment and helped to reduce stress for men, observations in line with the current study findings. According to Hollnagel et al. (2000) men handle stress by spending time and pursuing activities with their friends and families, and when they are idle or passive, they tend to feel weary. Most participants insisted that having a healthy lifestyle was an important protection from workplace burnout. Humour was also used to help ease the tensions and stresses that materialized during their shifts, and by joining social gatherings at work, they connected better with their colleagues. Espinosa et
al. (2010) confirmed that some nurses used humour to deal with sad situations. Flowing from the use of humour, having positive, carefree, and cheerful attitudes at work to help male nurses enjoy life (Hollnagel, et al., 2000).

Overall, the study findings support the work of Lomas et al. (2012) who indicated that men are able to cope adaptively with difficult emotions, such as caring for dying patients. Although some might believe that male nurses experience pressure to ‘be a man’ by being emotionally tough, both inwardly (avoiding introspection) and outwardly (stoicism) (Lomas et al., 2013), participants in the study dealt with stress effectively by showing rather than hiding feelings. Indeed, it can be reasonably argued that participants sustained the challenges of caring for dying patients in the ICU through these purposeful strategies, some of which ran counter to masculine ideals.

**Supporting Male ICU Nurses in a Female-Dominated Profession**

The participants spoke about being stigmatized, since many people believe that nursing is a job best suited for women. In this study, some of the nurses concurred but most of the participants argued that the intensity of the bias had eased in the last decade. They suggested that the public was more receptive to the idea that male nurses are capable, sensitive, and caring. According to Brown (2009), some male nurses feel disadvantaged because they are in a profession dominated by women, which also confers a lower status upon them. The current study participants, however, saw themselves as equals to female nurses and genuinely enjoyed working in the female-dominated profession.

Work is one of the main ways by which a man’s identity is defined (Cecil et al., 2010). The participants argued that being happy in their workplace was essential, and it was garnered through having a sense of purpose, value, and even pride, especially when
their abilities were validated and accomplishments acknowledged by others. Oliffe et al. (in press) suggested that career can provide men with a sense of purpose that strengthens their self-esteem and purchase on masculine ideals. The current study findings ran counter to this in that no participants articulated nursing as a career; instead they saw it just as a job. In addition, many participants pursued happiness outside of work, such as in their relationships with family and friends, and by doing activities that they enjoy. This also runs counter to literature claiming men live to work rather than work to live.

Working in the female-dominated profession, most participants felt well supported by their female colleagues, especially during difficult times when they were caring for dying patients. They enjoyed their professional relationships with other nurses and their collaborations on the healthcare team. Some authors (e.g., Connell, 2005) have reported that men tend to compete with others in the workplace for promotion and/or acclaim. In the current study, such ambition was not articulated, although some participants reported conflicts and power struggles with doctors about what might be best for a dying patient. So while there was some evidence of challenging nurse–doctor hierarchies, participants did not reveal power struggles with other nurses. While this might be an artefact of the ICU environment and autonomy afforded to nurses, the finding contrasts longstanding reports of horizontal violence in nursing (e.g., Farrell, 2001; Taylor & Barling, 2004).

Summary

Working in the female-dominated profession, participants drew on masculine ideals to fulfil the provider’s role to meet the needs of patients and their families. They were also not afraid to show their feelings, which transgressed some masculine ideals where men were expected to be stoic and tough. In turn, verbally sharing emotions was understood and explained a way as reducing their stress. Moreover, shedding tears was
not accepted as a feminine attribute, but as a way for participants to show their investment in caring for others. Masculine ideals were also reconstituted after they witnessed their patients die. New perspectives emerged in their lives, to reveal an array of masculine ideals and practices (i.e., giving up on risky activities and learning to appreciate life more). Stress relief included partying, but for most their proactive efforts towards healthy lifestyles and a work–life balance were key. Similar to Emslie et al.’s (2004) findings, a ‘work to live’ attitude emerged, largely because of the exposures in their work (i.e., death, fragility of life). Most participants asserted that life was made up of various entities, and that their job was only one of them, which differs from the masculine ideals that suggest work and career are central for men.
CHAPTER 6: CONCLUSION

Recommendations

Several recommendations can be made with regards to men’s health, based on the study findings. After interviewing the participants and carefully analyzing the data, some strong biases still seem to persist against male nurses. Several participants indicated that male nurses are often misunderstood by the public, including their motivations for becoming nurses, competencies, and sexual orientations. Further research on male nurses’ intentions of choosing nursing as their profession, how they cope with stress as nurses, their ability to give and make the differences in nursing may contribute to eliminating the stereotypes about men in nursing. Nevertheless, stereotypes ignore the diversity and plurality evident within the category of male nurses. In addition, future research may build on the current study findings to reveal other aspects of male nurses’ identity work, as these insights may help to reconsider the espoused connections between idealized masculinities, work, and men’s careers. Public and healthcare professional education might also incorporate the strategies used by male ICU nurses to quell stress as a means of influencing the practices of other men and women.

According to Adinkrah (2012), the traditional exhortation is that “males [are] strong, resilient, and independent, and… [they] avoid any show of vulnerability and emotional weakness… [therefore], few, if any, social outlets and support systems [are available] for males to utilize to deal with a range of emotional stressors” (p. 480). In the current study, however, participants were willing to share their emotions and, as gender minority workgroup, male nurses in ICU need validation, affirmation, and support from colleagues and from the wider healthcare team. Nevertheless, few members of the healthcare team are aware of this situation, and managers may benefit from recognizing
the advantages of making improvements to support their male employees at work, especially when they are under stress and/or at risk for burn out.

This study also underscores the relationship between male nurses’ wellness and the quality of patient care in the ICU. Strategies for encouraging and supporting male ICU nurses, such as workshops to help them recognize their feelings and personal challenges, and/or to help others understand how to listen to them at the workplace, are therefore especially vital. These tools can help others learn how to address male nurses’ needs, while recognizing the importance of validating, supporting, and appreciating their work. The findings of this study may also inform other male ICU nurses about how to cope with stress and prevent burnout.

Limitations

Most participants reported that they overcame stresses when caring for dying patients and their families. Nevertheless, stress and burnout might not have been recognized by the participants and their answers may not reflect how they are perceived by others. Future research might include mixed-method designs to better measure and compare the participants’ self-reported stress levels. Such methods can reveal the participants’ degree of insight, which in turn can inform interventions for promoting male nurses’ health and well-being.

Comfort care performed on dying patients has been well defined and established across Canada, and the current study was conducted in two hospitals in Vancouver. Since healthcare systems in other countries differ from the Canadian public healthcare model, and definitions of comfort care also tend to vary, the current study findings are limited in their applicability for male ICU nurses in other countries. Again, this limitation could
direct future researchers to investigate male ICU nurses in other countries, especially
given the global shortage of nurses.

**Conclusions**

This study described the experience of male ICU nurses in taking care of dying
patients and their families. The findings reveal that male ICU nurses are committed to
delivering humane care in providing comfort and reducing fear and distress when a
patient is in the process of dying. This project addressed questions about the needs of
male ICU nurses and the findings signal how others can support them at the workplace.
While the findings from this study will primarily be used for this Master’s thesis, they
will also be presented in journal articles and presentations to guide future research and
nursing practice.
REFERENCES


APPENDIX A: DEMOGRAPHIC ASSESSMENT RECORD

Which hospital and what type of ICU do you work currently?

How long have you been an ICU nurse?

Are you a full-time or part-time employee?

What is your sexual orientation?

- Heterosexual
- Homosexual
- Transgender
- Other: _______________

Do you live with a partner/significant other?

Did you receive your nursing education/training in Canada? Or from other countries?

What is your level of education?

What is your ethnicity?

How old are you?
APPENDIX B: CONSENT

University of British Columbia School of Nursing

Consent Form

ICU Male Nurses’ Experiences in Taking Care of Dying Patients

Principal Investigator:
Dr. John Oliffe
UBC School of Nursing
604-822-7638

Co-Investigator:
Tammy Wu
Master of Science in Nursing
UBC School of Nursing
604-377-3476

This research study is part of a thesis (public document) for a Master of Science in Nursing (MSN) graduate degree.

Sponsor:
No grant

Purpose:
The purpose of this project is to explore the experiences of male ICU nurses in taking care of dying patients at their workplace. Male ICU nurses, who work in various types of intensive care units (ICU) from various hospitals, and who represent diverse ethnic groups and have experiences with taking care of dying patients, are invited to participate in this research study.

Study Procedures:
After you are enrolled in the study, the investigator will arrange for an interview with you. The interview will last up to a maximum of two hours. In some cases, a second interview may be needed for clarification or to gather more information. Interview(s) will be audio-taped to ensure the accuracy of the conversation, and confidentiality will be maintained at all times. Upon request, you will be allowed to review and comment on the draft of the research report to help prevent any misinterpretation of your intended meaning and to provide your response in relation to the study findings. A brief review of the findings will be provided in PDF format to achieve this purpose.

Potential Risks:
This study involves minimal risk to participants and is unlikely to adversely affect the rights and welfare of participants. During the interview, you will be asked to describe your memories/stories/experiences about taking care of dying patients; therefore, some psychological impact (i.e., sadness, negative emotions/discomfort, etc.) count be encountered during and after the interview. To manage this possibility, information about counselling services that are available at your workplace can be provided.
Potential Benefits:
Participants may or may not benefit from participating in the study.

Confidentiality:
After each interview, the digitally recorded data will be password-protected and stored on the server at UBC to maintain confidentiality. All documents will be identified only by a code number and kept in a locked filing cabinet. Participants will not be identified by name in any reports for the completed study. No data will be stored or downloaded onto unsecured computers or on the Web to prevent copying. Raw data can be accessed only by the principal investigator, the co-investigator, or committee members.

Remuneration/Compensation:
To defray any costs for inconvenience/transportation, each participant will receive an honorarium in the amount of CDN$20, as a coffee gift card. No cash reimbursement for any other expenses will be provided.

Contact Information for the Study:
If you have any questions or desire further information with respect to this study, you may contact Tammy Wu at 604-377-3476 or Dr. John Oliffe at 604-822-7638

Contact for Concerns about the Rights of Participants:
If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject information Line at the UBC Office of Research Services at 604-822-8598 or send email to RSIL@ors.ubc.ca

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or may withdraw from the study at any time without jeopardy to your employment. If you withdraw from the study, any data that you provided will be removed prior to the analysis.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature also indicates that you consent to participate in this study.

_____________________________________________________
Participant Signature Date